THE STATE BAR OF CALIFORNIA
INSURANCE LAW COMMITTEE of the BUSINESS LAW SECTION

APPELLATE LAW UPDATE

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CALIFORNIA SUPREME COURT: There were no Supreme Court insurance law developments this month.

CALIFORNIA COURT OF APPEAL: The California Court of Appeal published six decisions that are of interest to attorneys practicing insurance law.

1. **Third parties have no standing to request an insurance company add them as an additional insured under a policy following a loss.** *The Boeing Co. v. Continental Casualty* (Nov. 20, 2007, B194996) __ Cal.App.4th __ [07 D.A.R. 18419].

The insured in this matter, CIA, is a nonprofit corporation that enlists volunteers to repair and rehabilitate the homes of low-income, elderly and disadvantaged persons. It solicits companies such as Boeing to encourage its employees to volunteer for its charitable projects. The plaintiff, an employee of a California State University, was allegedly injured while working as a volunteer on such a project. He sued both Boeing and CIA, asserting they acted as joint venturers with his employer of the project, that his volunteer work was performed under Boeing's direction and control, and that his injury stemmed from the use of a defective step-stool supplied by Boeing. Boeing tendered its defense to CIA's insurer, who declined coverage. Boeing spent more than $100,000 on its successful defense against the underlying lawsuit, and then sued CIA's insurer for breach of its alleged duty to defend.

The trial court sustained the insurer's demurrer to Boeing's complaint. The Court of Appeal affirmed, holding that "Boeing is incapable of alleging status as an additional insured" because the policy specified that CIA, as the named insured, had the sole authority to request changes to the policy and that Boeing therefore "had no standing to make written request to [the insurer] to be named as an additional insured under the policy."

2. **Insurer has no duty to defend defamation suit under homeowner's policy where the insured's alleged liability did not stem from an accident or occurrence.** *Stellar v . State Farm General Ins. Co.* (Nov. 27, 2007, B195728) __ Cal.App.4th __ [07 D.A.R. 18593].

State Farm issued a homeowner's policy to Richard Stellar and his wife, covering them for certain liability caused by an "occurrence," which was defined to mean "an accident" that results in bodily injury or property damage. The insureds sued Philip Stellar (Richard's brother) for defamation, intentional infliction of emotional distress and intentional interference with contract. Philip answered and filed a cross-complaint against Richard and Miles Stellar (Richard's father), alleging causes of action for slander per se, libel and intentional infliction of emotional distress. In support of his causes of action Philip's complaint alleged five incidents involving statements about him molesting children, using drugs, and gambling made by Richard or Miles to various government employees and private persons. Richard and Miles tendered their defense against Philip's cross-complaint to State Farm, which declined the tender on the ground it failed to allege either an "occurrence" or any claim for bodily injury.

Richard and Miles sued State Farm for breach of contract, insurance bad faith, and declaratory relief. The trial court granted State Farm's motion for summary judgment. The Court of Appeal affirmed, holding that "'[t]he very nature of defamation precludes the conclusion that it can occur "accidentally"'" and that the only alleged injury to Philip stemmed from "an underlying [defamation] claim that was not covered by the policy."

3. **Trial court abuses its discretion by denying class certification in action seeking relief under UCL for post-claim underwriting of disability policies in violation of Health & Safety Code.** *Ticconi v. Blue Shield of Cal. Life & Health Ins. Co.* (2007) 157 Cal.App.4th 707.

Plaintiff Augusto Ticconi sued his health insurance provider, Blue Shield under the Unfair Competition Law, alleging that Blue Shield violated Insurance Code sections 10113 and 10381.52 by failing to attach his application to or endorse it on his insurance policy when issued and later rescinding the policy on the ground he had made misrepresentations in that application. The trial court denied Ticconi's motion for class certification of similarly situated insureds on the ground that Blue Shield's defenses of fraud and unclean hands raised individual issues that predominated over the common issues related to liability.

The Court of Appeal reversed, holding that the trial court erred when it denied class certification because Blue Shield's equitable defenses cannot be used to defeat a UCL cause of action and because, pursuant to Insurance Code sections 10113 and 10381.5, Blue Shield can not assert the defense of fraud based on statements that insureds made in an application for insurance where the application had been neither attached to nor endorsed on the policy when issued. The court explained that where, as here, equitable defenses may not be used to wholly defeat the UCL cause of action and where the insurer may not raise a defense based on misstatements made in unattached and unendorsed applications "the diverse facts making up Blue Shield Life's fraud and unclean hands defenses are not to be factored in when determining whether the community of interest requirement is met."

4. **An insured who settled its coverage claim and released its insurer from further liability may keep the settlement proceeds and sue the insurer for misrepresenting the policy limits in order to recoup the difference between the settlement amount and the amount the parties would have agreed upon to settle the claim had there been no misrepresentation.** *Village Northridge Homeowners Assn. v. State Farm Fire & Cas. Co.* (Dec. 17, 2007, B188718) __ Cal.App.4th __ [07 D.A.R. 18547].

An insured homeowners association settled disputed claims arising from the Northridge earthquake with its insurer. The insurer paid $1.5 million to the insured in exchange for the insured's release of all claims or causes of action it had or may have arising out of its earthquake claim. Two years later, the insured sued the insurer for breach of the insurance contract and insurance bad faith, alleging that the insurer had undervalued the cost of repairs, improperly induced the insured to forego payments due under the policy, and wrongfully compelled the insured to release its claims against the insurer before paying part of the benefits owed under the policy. The insurer successfully moved for summary judgment on the ground the insured's release barred the lawsuit. The Court of Appeal reversed that summary judgment in a prior appeal, holding that there were triable issues of fact concerning the actual limits of the insured's earthquake coverage and whether the insurer had misrepresented those limits to the insured during its adjustment of the claim. On remand, the insurer successfully moved for judgment on the pleadings on the ground the insured could not sue on the policy without first rescinding the settlement agreement and release, and that it could not rescind without first restoring to the insurer the $1.5 million consideration the insurer paid under that agreement.

The Court of Appeal reversed once again, holding that the insured had the option of affirming the settlement agreement and recovering damages for the insurer's fraudulent misrepresentation of policy benefits, measured by the difference between the $1.5 million already paid by the insurer in settlement of the earthquake claim and the amount the parties would have agreed to settle that claim for had there been no misrepresentation of policy benefits. The court reasoned that the Supreme Court's decision in *Garcia v. California Truck Co.* (1920) 183 Cal. 767, 773 [holding that a plaintiff cannot avoid a fraudulently induced contract of release without rescinding the contract and restoring the money paid as a consideration for the release], applies only to personal injury lawsuits. The court also reasoned that damages "calculated based on the amount for which the parties would reasonably have settled had the [insured] known the actual policy limits" were not too speculative to support the claim.

5. Health insurer's attempt to rescind policy based on misrepresentations in application after a substantial claim in excess of premiums paid supports insurance bad faith and intentional infliction of emotional distress causes of action. *Hailey v. California Physicians' Service* (Dec. 24, 2007, G035579) __ Cal.App.4th __ [07 D.A.R. 18941].

An insured applied for health insurance from Blue Shield for herself and her family, but responded to questions on the application based only on her own health information neglecting to include information regarding her family's health issues. After securing coverage from Blue Shield she declined to seek coverage under a group policy offered by her new employer. About a year later, the insured's husband was hospitalized for stomach problems. In response to this claim, Blue Shield referred the contract to its "Underwriting Investigation Unit" to investigate possible fraud in the coverage application. During this investigation, Blue Shield secured the family members' medical records that reflected adverse health information that was not included on the application. One month later, the husband was involved in an automobile accident that left him permanently disabled and required medical services costing Blue Shield nearly $500,000. Three months after the auto accident Blue Shield sent the insureds a letter cancelling the policy retroactively and demanding that they pay the difference between the premiums and the medical expenses paid by Blue Shield.

The insureds sued Blue Shield for breach of contract, insurance bad faith, and intentional infliction of emotional distress. The trial court granted Blue Shield's demurrer to the IIED cause of action and granted Blue Shield's motion for summary judgment on the remaining claims. The trial court ruled that Blue Shield's decision to rescind the policy was justified by the misrepresentations made by the insured on the application for coverage. It also awarded Blue Shield more than $100,000 on its cross-complaint.

The Court of Appeal reversed, holding that Health and Safety Code section 1389.3 "precludes a health services plan from rescinding a contract for a material misrepresentation or omission unless the plan can demonstrate (1) the misrepresentation or omission was willful, or (2) it had made reasonable efforts to ensure the subscriber's application was accurate and complete as part of the precontract underwriting process." The court further held that both of these issues turn on disputed facts that cannot be resolved on summary judgment, that a triable issue of facts also exists regarding whether Blue Shield engaged in bad faith, and that the insureds adequately alleged a cause of action for intentional infliction of emotional distress.

The court explained that a provider cannot "'complete medical underwriting' within the meaning of section 1389.3 by blindly accepting the responses on a subscriber's application without performing any inquiry into whether the responses were the result of mistake or inadvertence." Rather, the provider must "make reasonable efforts to ensure a potential subscriber's application is accurate and complete" as part of its medical underwriting process. Although Blue Shield is regulated by the Department of Managed Heath Care not as an insurance company, and the Insurance Code and regulations do not apply directly to it, the Court of Appeal nevertheless found that its decision was consistent with insurance decisions. Finally, the court reasoned that Blue Shield's failure to promptly rescind the policy after learning of the misrepresentations in the application presented a triable issue of fact whether it was liable for insurance bad faith and intentional infliction of emotional distress by delaying its decision to rescind until after the cost of claims exceeded the earned premiums.

6. **Insurance company is liable for default judgment entered against its insured unless it proves actual prejudice from lack of notice of the lawsuit; i.e., a substantial likelihood that it would have achieved a more favorable result if given an opportunity to defend its insured.** *Belz v. Clarendon Am. Ins. Co.* (Dec. 28, 2007, B193314) __ Cal.App.4th __ [08 D.A.R. 7].

A homeowner hired a contractor to erect an additional building on his property, and then sued the contractor for defective construction. The contractor did not answer or defend, and did not notify his liability insurer about the lawsuit. The insurer learned of the lawsuit after a default was entered, and unsuccessfully moved to set aside the default. The homeowner then brought a direct action against the insurer to recover the amount awarded by the ensuing default judgment. The insurer defended on the ground there was no coverage pursuant to a policy provision stating that the insurer "'shall have *no liability* for any *default judgment entered against any insured*, nor for any judgment, or settlement or determination of liability rendered or entered *before notice to the Company* giving the Company a reasonable time in which to protect its and its insured's interests . . . .'" The trial court granted the insurer's motion for summary judgment on the ground the policy did not cover a default judgment entered without timely notice of the lawsuit, ruling that the insurer did not need to prove prejudice.

The Court of Appeal reversed, holding that "where a default judgment results from a lack of notice by the insured, (1) the insurer is liable on the judgment unless it suffered actual, substantial prejudice, and (2) the mere inability to investigate the claim thoroughly or to present a defense in the underlying suit does not satisfy the prejudice requirement." The court reasoned that the pertinent policy provision was a "notice provision" that was enforceable only upon proof of actual prejudice based on the lack of notice, rather than a "no-voluntary payment provision" that could be enforced without a showing of prejudice, since the underlying lawsuit resulted in a judgment *against* the insured rather than a voluntary payment *by* the insured. The court also explained that the insurer had to show *actual*, not merely *possible*, prejudice from the lack of timely notice, which required the insurer to prove there was a "'substantial likelihood that, with timely notice . . . it would have settled the claim for less or taken steps that would have reduced or eliminated the insured's liability.'"

NINTH CIRCUIT COURT OF APPEALS: There were no Ninth Circuit insurance law cases published this month.